Liaison Service – Psychiatry of Old Age, North Tyneside General Hospital

Profile of Learning Opportunities

DATE LAST UPDATED: July 2012 by Lynne Harrison and Joanne Leck
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Area Profile

Area Covered

The Liaison service covers North Tyneside General Hospital, which is a small hospital with approximately 450 beds.

The Service

The team comprises of:
6 sessions weekly Consultant Psychiatrist
1 30hr week Band 7 RMN
3 full time Band 6 RMN

The Liaison Service is able to accept referrals from the medical wards asking for an opinion, advice or treatment plan for patients with mental health needs.

We also deliver training to staff on the causes and recognition of mental health needs, focusing primarily on Dementia, Delirium and Depression. This training can be on a formal basis, but also includes informal training and discussions about these needs.

In addition we have an ongoing involvement with decisions about the environment and how to make this more relevant to mental health needs.

Rationale for Service

“Older people occupy two thirds of NHS beds and 60% of older people admitted to general hospital will have or will develop a mental disorder. This mental disorder will predict a poor outcome for the older person and the service.”

Who cares Wins. (Working group for Liaison Mental Health Services for older people, Faculty of Old Age Psychiatry, Royal College of Psychiatrists – January 2005)
**Off Duty**

General work patterns:

Monday – Friday  
8:30 – 4:30

Some flexibility in this, with regard to start and finish times.

**Useful Information**

You will be contacted two weeks prior to your allocation.

**Uniform**

Uniform of white tunic and trousers required, there may be some occasions where mufti can be worn.

Do not travel to and from work in uniform.

*For further information please refer to the trusts clothing and dress code policy available on the intranet.*

**Telephone Number:** 0191 2354900

**Named Person responsible for POLO document:**  
Roisin McLaughlin

**Polo review date:** July 2013
**Kielder Unit**

This unit is a joint working venture between Helen McArdle and the hospital. It is a unit of 15 beds, primarily for those patients who have had a delirium or another mental health issue and need a little more time to recover. It is staffed by Helen McArdle. However on a day to day basis there is input from the trust in the form of a Consultant Physician, an OT, Physiotherapy, social workers and a mental health nurse.

It is set up to run just like a residential home, with daily routines, encouraging independent activity and a person centred care approach.

The patients receive a full Multi Disciplinary Team Assessment and ongoing work with the level of functioning, aiming to restore them to their previous level of functioning.

Early indications are that we have managed to return 50% of the patients to their own home.
Learning Opportunities
Interpersonal Skills

- **Assist with Psychological and Social Needs**
  - Monitor, observe and document problems highlighted with patient’s mental health for example evidence of low mood, delusional belief system, hallucinations, the voicing of suicidal ideation or intent etc.
  - Become familiar with the documentation used and nurses responsibilities in relation to the Mental Health Act through scenario or practice.
  - Planning, Participating and taking the lead in one to one and group activities
  - Planning and facilitating in Relaxation Group
  - Engage in one to one therapeutic conversation with patients
  - Arrange as appropriate visits to hospital café/shop or other therapeutic outing such as home visits escorts.
  - Document and feedback as required in relation to the above.

- **Attending Out Patient appointments to support patients and take an opportunity to learn**
  - ECG
  - X ray Dept
  - ECT
  - MRI
  - Cat Scan

Clinical Skills

- **Overview**
  - Admission and discharge process
  - Psychiatric disorders
  - Mental Health Act
  - Observation levels
  - Care pathways
  - Communication Skills
  - Ward rounds/ multi-disciplinary meetings
  - Case conferences
  - Accessing other services/ resources
  - Working within a multi-disciplinary team
  - Physical disorders of the older adult in particular
• Practical Experience
Become familiar with the following practical skill:
- Assist patients to perform specific Activities of Daily Living as highlighted in Care Plans and under supervision as necessary: Washing and dressing, bathing, eating and drinking, toileting.
- Monitor food and fluid intake
- Monitor elimination process
- Temperature, Pulse, Respiration, Blood pressure and Saturations monitoring
- Urinalysis, Taking mid stream specimen of urine and 24 hour urine collection
- Take sample of faeces for occult blood
- Take Swabs for MRSA: Nose and Groin and other swabs requested
- Document and feedback as required in relation to the above

• Medicines Management
- Familiarise with Medicines Management Policy
- Observe medications being dispensed

Health Promotion Opportunities

• Understand the need to refer to other Specialist Teams within the trust
- Tissue Viability Nurse Specialist
- Diabetic Resource Centre
- Availability, Location and distribution of information relating to:
Larger Multi-Disciplinary team
ADDITIONAL LEARNING OPPORTUNITIES SPECIFIC TO AREA OF PRACTICE

- Education around Delirium
  - *NICE guidelines*
  - *Protocol*

- Assessment of capacity
  - *MC Act*
  - *Best interest decisions*

- Mental Health in an acute care setting
  - *Causes of*
  - *Treatment*
  - *Prevention*

- Teaching
  - *Planning*
  - *Delivering*
  - *Evaluating*

- Assessment

- Care Planning

- Evaluation

- Liaison with other healthcare professionals
  - *Working primarily with people*
  - *Limited mental health experience*

- Monitor effects of medication (No administration of medication experience)
• Challenging perceptions of mental health, promoting a positive image.

• Audit process

• Comparing and contrast different care settings (Kielder Unit Vs. Hospital setting)

• Cognitive Assessment

• Cognitive Testing

• Cognitive Enhancers

• MDT’s – feedback

• Nurse Assessors – PCT

• Referral Systems

• Report and Letter writing
**STUDENT NURSE INDUCTION/ORIENTATION CHECKLIST**

**STUDENT NAME:** ...................................... .... **MENTOR NAME:** ....................................................

**PLACEMENT DATES** .................................. **TO** ............................................................. **INTAKE & BRANCH** .....................................................

This document is for purposes of ensuring that a student to your area is inducted /orientated appropriately. This is a pre requisite to any student being allocated to your ward in line with the NMC standards for placement learning.

Students MUST be allocated a main mentor for their placement time and they MUST have the relevant qualifications and work 40% of the placement time directly with the student. This is to meet the requirements of the NMC and to be able to accurately complete the final interview and assessment of the student. The student’s off duty should be recorded for the wards records. This can be on the ward off – duty or equivalent. Other methods can be used but must be dept and accessible if the QAA or NMC wish to view them. This should be a minimum of three years (students training time).

Orientation checklist. Complete and retain in POLP file (copy can be given to student to give GP for student file at UNN).

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<thead>
<tr>
<th>TOPIC</th>
<th>STUDENT SIGNATURE</th>
<th>MENTOR SIGNATURE</th>
<th>DATE</th>
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<tbody>
<tr>
<td>Meet with nominated mentor on first day and regularly afterwards</td>
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<td>(identify a co /associate mentor when necessary)</td>
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<td>Discuss responsibilities of student and facilitator to meet portfolio of learning, also responsibility of student to staff and Trust while on placement</td>
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<td>Provide/ show student portfolio of Learning opportunities (polo)</td>
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<td>Provide any relevant handouts the area provides to students</td>
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<td>If not done organise off – duty (NB 50% time must be with mentor)</td>
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<td>Orientation to immediate working environment</td>
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<td>Orientation to appropriate wider hospital areas</td>
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<td>Introduction to staff throughout placement</td>
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<td>Introduction to patients/clients and informed of responsibilities towards them</td>
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<td>Complaints procedure</td>
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<td>Risk Policy Trust and UNN</td>
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<td>Any relevant time back in UNN while on placement for exams</td>
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<td>Any potential problems expected while on placement</td>
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<td>Discuss Emergency procedures. Fire/Resuscitation/other</td>
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<td>If witness any un-toward events</td>
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<td>Where Trust policies and Procedures are (Hard and Electronic Copies)</td>
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<td>Relevant Nursing documentation</td>
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<td>Emergency exits</td>
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<td>Fire points &amp; extinguishers</td>
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<td>Changing areas</td>
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<td>Break area’s &amp; facilities (including break times)</td>
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<td>Emergency equipment i.e Resuscitation trolley</td>
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<td>Other (Add as necessary overleaf)</td>
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<td>Parking areas</td>
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<td>Bus Routes</td>
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<td>Security issues</td>
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Kielder Unit Student Placement Schedule

This Student Schedule has been produced to facilitate the achievement of learning objectives whilst on placement on Kielder unit. It has been designed to the generic needs of all students and as a result is adaptable to suit the individual needs of the student at whatever stage of their specific course for example Diploma, degree or Post Registration.

*I possible arrangements can be made for the students to visit Kielder Unit before their placement, become familiar with the ward and meet their mentor.*

**Week one:** Familiarize self with ward routine, follow enclosed checklist to assist with orientation process, Read POLO and ward objectives, meet patients and staff, become aware of nursing and multidisciplinary (MDT) documentation used on the ward and the location of Policy and Procedure Documentation.

*Follow the programme outlined below after week one as appropriate to student’s stage of learning for example 1*\textsuperscript{st}, 2*\textsuperscript{nd} or 3*\textsuperscript{rd} year as required by student and mentor learning objectives*

**MDT meeting preparation**
- Initially attend and observe the MDT process
- Prepare documentation and present specific patients at MDT
- Follow through any outcomes via appropriate methods/channel of communication

**Medicines Management**
- Administration of medication using following routes
  - Orally
  - Intra Muscular injection Depots and others
  - Subcutaneous injection
  - Subcutaneous Fluids administration
  - Familiarize with Medicines Management Policy
  - Observe medications being dispensed
Then dispense under supervision when deemed ready by mentor/student

Follow nursing Process Pathway
If possible follow patient through admission to discharge

- Assess
- Plan
- Implement
- Evaluate care throughout
  1. Initial Assessment Care Plan
  2. Intermediate Care Plan
  3. Discharge Care Plan
  4. Specific risk Assessment Care Plans
  5. Follow admission Procedure see List
  6. Follow Discharge Procedure see list

Gain Overview of Psychiatry of Old age MDT Services

Arrange visits with the following to gain an understanding of their role within POAS.

- Community Psychiatric Nurse
- Social Worker
- Occupational Therapist
- Ward 19
- Tynemouth Court
- Priory Day Hospital
- Discuss validity of learning achieved with mentor on return.

Practical Experience.